Public Health Agency of Canada | Agence de la santé publique du Canada

Public Health Agency of Canada
2012–13

Departmental Performance Report

The Honourable Rona Ambrose, P.C., M.P.
Minister of Health

Canada

Table of Contents

Minister's Message **1**

Section I: Organizational Overview **2**

Raison d'être 2

Responsibilities 2

Strategic Outcome and Program Alignment Architecture (PAA) 3

Organizational Priorities 4

Risk Analysis 7

Summary of Performance 9

Expenditure Profile 11

Estimates by Vote 11

Contribution to the Federal Sustainable Development Strategy (FSDS) 11

Section II: Analysis of Programs and Sub-Programs by Strategic Outcome **13**

Strategic Outcome 13

Program 1.1: Public Health Infrastructure 14
Sub-Program 1.1.1: Public Health Capacity Building 16
Sub-Program 1.1.2: Public Health Information and Networks 17
Sub-Program 1.1.3: Public Health Laboratory Systems 18

Program 1.2: Health Promotion and Disease Prevention 20
Sub-Program 1.2.1: Infectious Disease Prevention and Control 22
Sub-Program 1.2.2: Conditions for Healthy Living 24
Sub-Program 1.2.3: Chronic (non-communicable) Disease and Injury Prevention 26

Program 1.3: Health Security 28
Sub-Program 1.3.1: Emergency Preparedness and Response 29
Sub-Program 1.3.2: Border Health Security 31
Sub-Program 1.3.3: Biosecurity 32

Program 2.1: Internal Services 34

Section III: Supplementary Information **37**

Financial Statements Highlights 37

Supplementary Information Tables 39

Tax Expenditures and Evaluations Report 39

Section IV: Other Items of Interest **40**

Organizational Contact Information 40

Web Sites 40

Minister's Message

I am pleased to present the *Public Health Agency of Canada's Departmental Performance Report* for fiscal year 2012–13. The report highlights the Agency's ongoing commitment to protect Canadians and empower them to improve their health.

In an increasingly interconnected world where public health issues know no borders, collaboration is essential to promoting the health, well-being and quality of life of Canadians. As a result, the Agency works regularly with its provincial and territorial partners on a wide range of nationally important public health issues, including food-borne illness investigations, immunization, healthy living and mental health. Internationally, the Agency works with key partners such as the World Health Organization to advance important global issues, including disease threats and health security.

To help Canadians prevent chronic diseases, the Agency supported collaborations among the public, private and voluntary sectors. The Agency partnered with AIR MILES for Social Change and the YMCA to encourage physical activity, and with the Boys and Girls Clubs of Canada and Sun Life Financial to expand the Get BUSY program. All sectors of society have a role to play in improving health, and the Agency's approach is leveraging expertise and resources to increase the impact and reach of programs and to test results for Canadians.

While encouraging Canadians to be active and to live healthy lifestyles, it is important that they do so safely. The Agency's Active and Safe initiative focused on preventing injuries among Canadian children and youth. In addition, a four-year initiative was launched with the Heart and Stroke Foundation of Canada to place automated external defibrillators in community hockey arenas across Canada.

Progress continued in preventing and controlling outbreaks of infectious diseases. Through its public health notices, surveillance data and various publications, the Agency informed Canadians and provided public health experts with tools to prepare and respond. The Agency extended its partnership with the Canadian Institutes of Health Research on the Influenza Research Network, to bring together leading influenza researchers from across Canada to identify new research and accelerate vaccine development. Agency laboratories continued to undertake world-class science and provide national leadership and co-ordination.

The results presented in this *Departmental Performance Report* demonstrate that the Agency, in collaboration with its partners, continues to be a world leader in public health and is helping to build a healthier Canada.

The Honourable Rona Ambrose, P.C., M.P.
Minister of Health

Section I: Organizational Overview

Raison d'être

Public health involves the organized efforts of society to keep people healthy and to prevent injury, illness and premature death. It includes programs, services and policies that protect and promote the health of all Canadians. In Canada, public health is a responsibility that is shared by the three levels of government in collaboration with the private sector, non-governmental organizations, health professionals and the public.

In September 2004, the Public Health Agency of Canada (the Agency) was created within the federal Health Portfolio to deliver on the Government of Canada's (GC) commitment to increase its focus on public health in order to help protect and improve the health and safety of all Canadians and to contribute to strengthening the health care system.

Responsibilities

The Agency has the responsibility to:

- Contribute to the prevention of disease and injury, and to the promotion of health;
- Enhance the quality and quantity of surveillance data and expand the knowledge of disease and injury in Canada;
- Provide federal leadership and accountability in managing national public health events;
- Strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning; and
- Serve as a central point for sharing Canada's public health expertise with international partners, and to translate international knowledge and approaches to inform and support Canada's public health priorities and programs—for example, by participating in international working groups to develop new public health tools to protect, mitigate and respond to emerging public health threats.

Strategic Outcome and Program Alignment Architecture (PAA)

The Agency restructured its Program Alignment Architecture (PAA) during the 2013–14 Management, Resources and Results Structure (MRRS) Amendment Process. Changes to the Strategic Outcome and PAA were approved by Treasury Board on February 22, 2013. For the purposes of this *Departmental Performance Report*, the Agency is reporting on its performance based on the 2013–14 MRRS.

Strategic Outcome	Program	Sub-Program	Sub-Sub-Program
Protecting Canadians and empowering them to improve their health	1.1 Public Health Infrastructure	1.1.1 Public Health Capacity Building	
		1.1.2 Public Health Information and Networks	
		1.1.3 Public Health Laboratory Systems	
	1.2 Health Promotion and Disease Prevention	1.2.1 Infectious Disease Prevention and Control	1.2.1.1 Immunization
			1.2.1.2 Infectious and Communicable Diseases
			1.2.1.3 Food-borne, Environmental and Zoonotic Infectious Diseases
		1.2.2 Conditions for Healthy Living	1.2.2.1 Healthy Child Development
			1.2.2.2 Healthy Communities
		1.2.3 Chronic (non-communicable) Disease and Injury Prevention	
	1.3 Health Security	1.3.1 Emergency Preparedness and Response	
		1.3.2 Border Health Security	
		1.3.3 Biosecurity	
	2.1 Internal Services	2.1.1 Governance and Management Support	2.1.1.1 Management and Oversight
			2.1.1.2 Communications
			2.1.1.3 Legal
		2.1.2 Resource Management Services	2.1.2.1 Human Resource Management
			2.1.2.2 Financial Management
			2.1.2.3 Information Management
			2.1.2.4 Information Technology
			2.1.2.5 Travel and Other Administrative Services
		2.1.3 Asset Management Services	2.1.3.1 Real Property
			2.1.3.2 Material
			2.1.3.3 Acquisitions

Strategic Outcome and PAA Crosswalk

Below is a table depicting the 2012–13 PAA and the 2013–14 PAA.

Financial Crosswalk to the 2012–13 Main Estimates ($M)

From 2012–13 PAA (columns) / To 2013–14 PAA (rows)	1.1 Science and Technology for Public Health	1.2 Surveillance and Population Health Assessment	1.3 Public Health Preparedness and Capacity	1.4 Health Promotion	1.5 Disease and Injury Prevention and Mitigation	1.6 Regulatory Enforcement and Emergency Response	2.1 Internal Services	Total
1.1 Public Health Infrastructure	65.4	17.8	38.5	0.2	2.6	0.8		**125.3**
1.2 Health Promotion and Disease Prevention		43.2	10.9	181.2	97.9			**333.2**
1.3 Health Security		3.6	35.7			23.3		**62.6**
2.1 Internal Services							95.4	**95.4**
Total	**65.4**	**64.6**	**85.1**	**181.4**	**100.5**	**24.1**	**95.4**	**616.5**

Note: All figures are rounded.

Organizational Priorities

Priority	Type	Program(s)
1. Managing Public Health Risks to Canadians	Ongoing	1.1, 1.2, 1.3
Summary of Progress		
Through the management of the Global Health Security Action Group, an international partnership of experts tasked with developing concrete actions to improve global health security, the Agency maintained the capacity to foster cooperative relationships for sharing information on emergencies/events of national and international significance. Canada's preparedness for epidemics and the capacity to detect and respond to food-borne illness and outbreaks was improved. Following recommendations in the *Evaluation of Food-borne Enteric Illness Prevention, Detection and Response Activities*, the Agency collaborated with its federal, provincial, and territorial (F/P/T) stakeholders to enhance linkages during national outbreaks, including ongoing invitations to the Chief Medical Officers of Health (CMOH) to participate in the Outbreak Investigation Coordinating Committees and engagement of the Inter-departmental Committee on Food Safety. Provincial public health laboratories were provided with protocols and methods to reliably test for emerging pathogens (e.g., influenza viruses). This information enabled provincial public health laboratories to augment testing capacities and increase Canada's preparedness to identify and respond to these emerging pathogens. Work continued with the Committee of Chief Veterinarians [composed of Chief Veterinary Officers from the provinces and territories (P/T)] through participation on the Antimicrobial Resistance (AMR) sub-committee to establish mechanisms to collect information on antimicrobial use, and to assist with the development of enhanced surveillance capacity at the P/T level.		

Legislation and regulations related to the use and manipulation of human and animal pathogens and toxins were administered and enforced. Regulations are being developed to support the implementation of the *Human Pathogens and Toxins Act* (HPTA). As well, processes and mechanisms were streamlined to facilitate regulatory compliance for biosecurity in Canada.

The Agency and its federal/provincial/territorial (F/P/T) partners undertook a review of the *National Immunization Strategy* (NIS) to propose areas of strengthened F/P/T collaboration for a more cohesive and consistent approach to immunization across the country.

Priority	Type	Program(s)
2. Promoting Health and Reducing Health Inequalities in Canada	Ongoing	1.1, 1.2
Summary of Progress		

Through programs such as the *Aboriginal Head Start in Urban and Northern Communities* (AHSUNC), the *Canada Prenatal Nutrition Program* (CPNP), and the *Community Action Program for Children* (CAPC), the Agency continued to support community-based groups and coalitions to deliver prevention and early intervention programs that promote the health and social development of vulnerable populations, which can include certain pregnant women, infants, children, and their families.[1] To address the public health priority of overweight and obesity, particularly in children, the Agency launched a new, multi-sectoral approach to healthy living and chronic disease prevention to support provinces and territories, the private sector and not-for-profit sector to work together, maximizing resources and promoting innovation. In addition, the Agency supported over 50 *Innovation Strategy*-funded projects in more than 300 communities to develop, test, and assess interventions designed to address evidence gaps and community needs in mental health promotion and in achieving healthy weights.

Emergency preparedness was enhanced among seniors and other at-risk populations by working with partners to complete *Enhancing Resilience Among High Risk Populations to Maximize Disaster Preparedness, Response and Recovery*, which developed tools for community action and intervention. In addition, the Agency welcomed Saskatchewan into the *Pan-Canadian Age-Friendly Communities Initiative*, bringing the number of jurisdictions involved to nine.

Priority	Type	Program(s)
3. Enhanced Public Health Capacity	Ongoing	1.1, 1.2, 1.3
Summary of Progress		

Public health officers and field epidemiologists were placed in jurisdictions across Canada in order to respond to both routine and emerging public health needs. As well, the deployment of field placement staff was supported to fill public health capacity gaps in areas such as epidemiology in all three territories to support their governments and regional health authorities on a time-limited basis. Training was provided via a number of channels including the *Skills Online* program for public health practitioners, and *Principles of Laboratory Biosafety* for researchers working with human pathogens and toxins.

Financial support was provided to six National Collaborating Centres for Public Health which produced a wide range of products and best practices in knowledge transfer, including an online registry of methods and tools as well as training modules for evidence-based decision making. The National Collaborating Centre on Environmental Health created a continuing education directory consisting of available courses, workshops, seminars, and conferences of value to public health professionals across North America. This directory included accredited courses recognized by the Canadian Institute of Public Health Inspectors, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada.

[1] These programs address mental health, injury prevention, and obesity by focusing on parenting skills, nutritional support, and education.

The *PHAC Surveillance Strategic Plan 2013–2016* was launched, which serves as a roadmap to renew the planning, alignment, and delivery of the Agency's public health surveillance activities. This will better position the Agency and its partners to continue to provide credible and timely public health surveillance intelligence to inform public health policy, decision making, and action.

In collaboration with provinces and territories, an *Operational Framework for Mutual Aid Response* was developed to coordinate surge requests for health care professionals to deploy during national and international emergencies.

Priority	Type	Program(s)
4. Achieving Excellence in Governance and Management	Previously committed	2.1

Summary of Progress

In June 2012, the Deputy Heads of HC and the Agency signed a *Shared Services Partnership (SSP) Framework Agreement* in which each organization retains responsibility for a different set of internal services and corporate functions. As a result:

- Agency and HC corporate policies, procedures and governance processes for the internal services functions were aligned and approaches standardized to promote service excellence, facilitate and accelerate decisions, and foster efficiencies and innovation.
- A significant amount of planning was done to support the implementation of the *Common Human Resources Business Process* (CHRBP). This included the analysis of all the various human resources processes and the identification and prioritization of the business enhancements opportunities to be implemented in order to comply with CHRBP by March 2014.
- Security governance structures, operating procedures, policies and frameworks were updated; a *Departmental Security Plan* was implemented; and a *Business Impact Assessment* tool with organization-wide coordinator training was developed to enhance business continuity planning. (SSP-HC-CSB)
- Initiatives fostering engagement and well-being were implemented which included a new process for managing harassment complaints, and training and awareness sessions for managers on the prevention and resolution of harassment.
- A cross-cutting branch committee was created to help senior management share results of the *2011 Public Service Employee Survey* and to engage employees in the development of a corporate action plan, which was approved in the 2012–13.

An internal realignment of functions was undertaken by the Agency to provide more strategic and tactical advice to support the Minister in advancing key federal public health priorities.

Treasury Board approval was received for the Agency's *Investment Plan (IP)* and a new, streamlined MRRS was implemented as the basis for its *2013–14 Report on Plans and Priorities* and its operational planning process.

In support of workplace wellbeing, a new *Policy on Prevention of Violence in the Work Place* was approved. As well, two mental health online tools were launched to equip managers and supervisors with the knowledge and skills to identify mental health issues/behaviours in the workplace.

Risk Analysis

Risk	Risk Response	Link to PAA	Link to Priority
Infectious Disease. There is a risk that emerging and re-emerging infectious diseases will continue to create the potential for epidemics and pandemics that will result in considerable health, social and economic impacts.	The Agency helped protect Canadians from risk factors associated with emerging/re-emerging infectious diseases by: • leading, and working collaboratively with provinces and territories to strengthen vaccine supply and address supply shortages; • strengthening infectious disease surveillance and applied public health research capacity; • working with partners to update the *Canadian Pandemic Influenza Plan for the Health Sector* (CPIP) based on H1N1 lessons learned and "all-hazards" risk management principles; and • conducting laboratory-based research, developing new laboratory tests, and investing in behavioural research to identify means by which to increase vaccine uptake among target populations.	1.2	1, 2, 3
Emergency Preparedness and Response. There is a risk that the Agency may not be able to respond effectively to new or unanticipated emergencies of high impact or high complexity.	The Agency strengthened its ability to respond to public health emergencies by: • using an all-hazards approach to complete the *Health Portfolio Strategic Emergency Management Plan* which clarified governance, decision-making mechanisms, and coordination within the Health Portfolio; • strengthening co-ordination of multi-jurisdictional public health events through the implementation of the *Food-borne Illness Outbreak Response Protocol* (FIORP), the CPIP, and *International Health Regulations* (IHR); and • strengthening inter-jurisdictional surge capacity and contributing to the resiliency of the public health system through the modernization of the National Emergency Stockpile System and development of the *Operational Framework for Mutual Aid Response*.	1.3	1, 3
Food-borne Illness. With current global trends in food production, preparation and distribution there is a continuing risk that food-borne illness will adversely impact the Canadian population with the potential for significant health, social and economic consequences.	To enhance the GC's ability to prevent, detect and respond to multi-jurisdictional outbreaks of food-borne illness, the Agency undertook a range of actions to enable transparent and timely information sharing and decision making, including: • strengthening collaboration with partners during national outbreaks, including ongoing invitations to the F/P/T Chief Medical Officers of Health to participate in Outbreak Investigation Coordinating Committees; and • developing a Web-based outbreak communications database, "*Outbreak Central*", which serves as a secure platform for information sharing among F/P/T food safety and public health partners during outbreak investigations.	1.2	1, 3

Chronic Disease and Health Promotion. There is a risk that overweight and obesity rates among children, youth and adults in Canada will continue to rise, therefore increasing the rate of chronic disease such as cancer, diabetes and cardiovascular disease.	In support of *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*, the Agency advanced a number of initiatives, including: • implementing new partnership arrangements and a new funding model for its grants and contributions investments in this area, with greater accountability, and improved reach and sustainability. Effectively addressing childhood obesity requires a sustained, multi-sectoral response involving the public, private, health professional, and non-governmental sectors. The new funding model requires that non-governmental organizations obtain matched funding from the private sector or charitable sectors to leverage additional reach and resources, thereby increasing effectiveness and "pay for performance" agreements ensure that payments are tied to tangible outputs; and • enhancing the Agency's surveillance capacity by establishing indicators for childhood, overweight and obesity trends and determinants impacting healthy weights.	1.2	1, 2, 3

Risk Narrative

The Agency operates within a dynamic and complex environment where domestic and international public health challenges continually evolve, highlighting the importance of ongoing planning and preparedness for public health emergencies. The multi-jurisdictional nature of public health also means that the Agency must work closely with domestic and international partners to respond and collaboratively build on lessons learned.

As set out in the table above, the Agency has identified four of its ten key risks, which were reported in its *2012–13 Report on Plans and Priorities* and *2012–13 Corporate Risk Profile* (CRP). These four risks were selected because they were ranked as having the highest likelihood of significant impacts on program delivery and the potential for consequences for Canadians. In addition, failure of any risk response strategy could impact the Agency's ability to protect and improve the health and safety of all Canadians.

The risk responses for these four risk areas, as identified in the 2012–13 CRP, were not modified or adjusted during the reporting period. Adjustments will be made to the Agency's CRP in 2013–14, including its risk response strategies, as part of an annual renewal process. In 2013, the Agency's Risk Management Oversight Committee completed a review of the risks identified in the 2012–13 CRP. The performance results reported during this review demonstrated that the management of these four risks were appropriate. Factored into this assessment were: the overall program performance against the performance indicators in which risk response strategies are embedded; Risk Lead assessment against key questions; and the integration of risk treatment strategies into the Agency's operational planning and other accountability processes. Collectively, these approaches enabled the Agency to assess the appropriateness and effectiveness of its management of the risks. Emphasis continued to be placed on enhanced disease prevention through surveillance and detection as key risk treatment strategies that were integral to success, primarily because of the role these activities play in enabling upstream interventions. The successful management of recent multi-player public health events, such as food-borne illness outbreaks and infectious disease prevention, illustrates the effectiveness of these upstream strategies.

Summary of Performance

Financial Resources – Total ($M)

Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending 2012–13	Total Authorities (available for use) 2012–13	Actual Spending (authorities used) 2012–13	Difference (Planned vs. Actual Spending) 2012–13
616.5	616.5	664.4	619.7	(3.2)

Total Authorities are higher than Planned Spending by $47.9M mainly due to inclusion of additional authorities for the operating and capital budget carry forward; authorities related to the SSP; and additional funding received for the liquidation of severance pay due to revisions to specific collective agreements.

Actual Spending was less than Total Authorities mainly due to lower spending for the pandemic vaccine fill-line; lower orders received from provinces and territories for the National Antiviral Stockpile (NAS); and expenditure reductions achieved through streamlined administration.

Human Resources (Full-Time Equivalents — FTEs)

Planned 2012–13	Actual 2012–13	Difference 2012–13
2,668	2,218	450

The variance between Planned and Actual FTE utilization is 450 FTEs, which is mainly due to the transfer of various programs between HC and the Agency as part of the SSP; and the implementation of business transformation initiatives and streamlined administration.

Performance Summary Table for Strategic Outcome and Programs ($M)

Strategic Outcome: Protecting Canadians and empowering them to improve their health

Program	Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending			Total Authorities (available for use) 2012–13	Actual Spending (authorities used)			Alignment to Government of Canada Outcomes
		2012 –13	2013 –14	2014 –15		2012 –13	2011 –12	2010 –11	
1.1 Public Health Infrastructure	125.3	125.3	135.1	124.5	147.8	137.4	142.1	148.1	*Healthy Canadians*
1.2 Health Promotion and Disease Prevention	333.2	333.2	311.7	350.4	330.6	315.7	330.1	319.4	
1.3 Health Security	62.6	62.6	48.9	43.2	76.6	60.1	45.2	37.8	*A Safe and Secure Canada*
Sub-Total	521.1	521.1	495.7	518.1	555.0	513.2	517.4	505.3	

Performance Summary Table for Internal Services ($M)

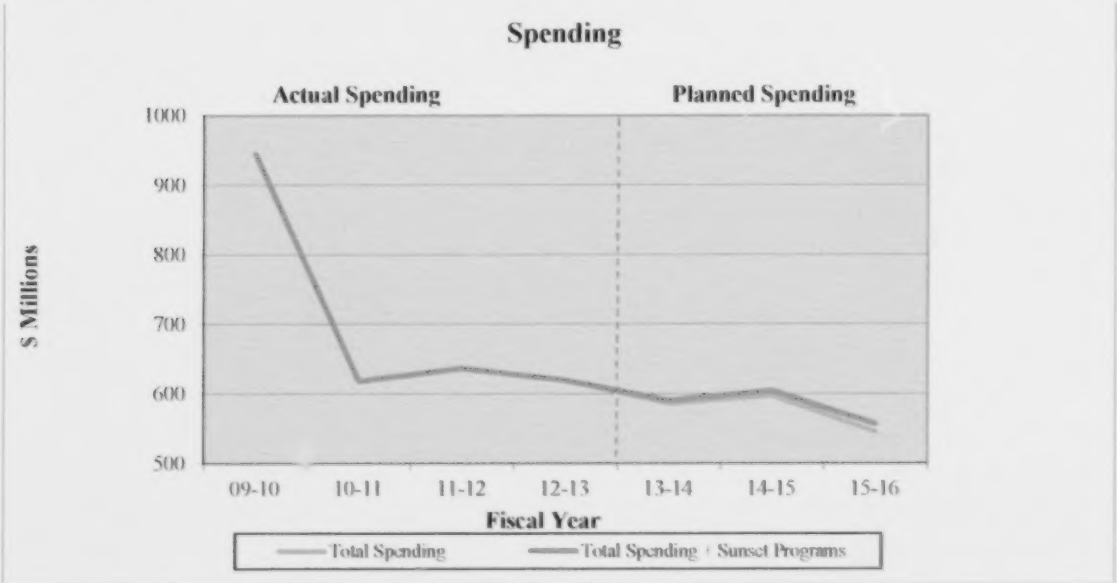
Internal Services	Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending			Total Authorities (available for use) 2012–13	Actual Spending (authorities used)		
		2012–13	2013–14	2014–15		2012–13	2011–12	2010–11
Sub-Total	95.4	95.4	90.9	79.8	109.4	106.5	119.1	112.8

Total Performance Summary Table ($M)

Strategic Outcome and Internal Services	Total Budgetary Expenditures (Main Estimates) 2012–13)	Planned Spending			Total Authorities (available for use) 2012–13	Actual Spending (authorities used)		
		2012–13	2013–14	2014–15		2012–13	2011–12	2010–11
Total	616.5	616.5	586.6	597.9	664.4	619.7	636.5	618.1

In 2011–12, the Agency's Actual Spending was higher than in the previous year primarily due to severance payouts as a result of revisions to specific collective agreements and increases in spending on transfer payments. 2012–13 Actual Spending and 2013–14 Planned Spending reflect lower levels of spending due to savings measures achieved through streamlined administration. In 2014–15, Planned Spending increases slightly over the previous year as the Agency makes the final payment of $49.7M under the Hepatitis C Health Care Services Program.

Expenditure Profile



Canada experienced an H1N1 Pandemic Influenza in 2009–10 which accounted for approximately $310M of additional spending in that year. The Agency also spent $49.7M in the same year on the Hepatitis C Health Care Services Program which provides funding to the provinces to compensate for the care of individuals infected with hepatitis C. This program provides payments every five years and the final payment will occur in 2014–15.

The decrease in planned spending from 2011–12 through 2014–15 is primarily due to expenditure reductions achieved through reduced spending on management and administration, travel, and professional services, as well as administrative efficiencies in delivering grants and contributions programs. Planned spending will increase in 2014–15 and subsequently decrease in 2015–16 as the Agency makes the final payment of $49.7M under the Hepatitis C Health Care Services Program in 2014–15.

Estimates by Vote

For information on the Agency's organizational Votes and/or statutory expenditures, please refer to the *Public Accounts of Canada 2013 (Volume II)*. An electronic version of the Public Accounts 2013 is available on the Public Works and Government Services Canada's Web site.

Contribution to the Federal Sustainable Development Strategy (FSDS)

The *Federal Sustainable Development Strategy* (FSDS) outlines the GC's commitment to improving the transparency of environmental decision making by articulating its key strategic environmental goals and targets.

The Agency includes the consideration of these outcomes as an integral part of its decision-making processes. The Agency contributes to the following FSDS 2010–2013 themes as denoted by the visual identifiers and associated programs below.

(Theme I: Addressing Climate Change and Air Quality)

Sub-Program 1.2.1: Infectious Disease Prevention and Control

(Theme IV: Shrinking the Environmental Footprint – Beginning with Government)

Program 2.1: Internal Services

During 2012–13, the Agency was compliant with the *Cabinet Directive on the Environmental Assessment of Policy, Plan and Program Proposals*.

For additional details, please refer to Section II of the DPR and the Agency's Sustainable Development Web site. For complete details on the FSDS, please visit the Environment Canada Web site.

Section II: Analysis of Programs and Sub-Programs by Strategic Outcome

Strategic Outcome

Strategic Outcome: Protecting Canadians and empowering them to improve their health		
Performance Indicators	**Targets**	**Actual Results**[2]
Health-adjusted life expectancy (HALE) at birth	Baseline to be established	Women – 71.2 years Men – 68.9 years (2007)
Health-adjusted life expectancy (HALE) at birth between the top-fifth and bottom-fifth income groups	Baseline to be established	Women – 7.6 years difference Men – 7.7 years difference (2007)

Social, economic, environmental, behavioural, and genetic factors have a major impact on the health and overall life expectancy of the population. Standard (or ordinary) life expectancy is the average number of years a person would be expected to live, starting at birth. In comparison, HALE is a summary measure of the average number of years that an individual is expected to live in a healthy state (i.e., it combines both quantity of life and quality of life). As such, HALE provides a better measure of the burden of disease and injury in the population—and how risk factors impact this burden—and can provide insight into the performance of public health efforts and/or where future efforts should be placed. Furthermore, HALE is a promising but relatively new indicator[3] with room for future methodological research and development.

In 2012–13, the Agency published the *Health-Adjusted Life Expectancy in Canada: 2012 Report by the Public Health Agency of Canada*, which found that chronic diseases and conditions such as diabetes, cancers and hypertension are associated with a significant loss in HALE. The Report also reviewed research evidence that shows Canadians have been experiencing continuing increases in life expectancy and in HALE. While the reasons for this increase are unknown, research suggests that decreases in the rates of cancer and heart disease due to improvements in the health care system and in chronic disease interventions could have played a role.

The Agency's programs—undertaken in collaboration with F/P/T governments[4], academia, non-governmental organizations, and international health partners—provide leadership and support in promoting health, reducing health inequalities, enhancing public health capacity, preventing and mitigating injuries and chronic and infectious diseases, providing relevant research support, monitoring health and disease situations and trends, and reducing the risk and consequences of public health events. Better knowledge about the nature and extent of inequalities in health due to socio-economic status and the presence of chronic diseases can help to guide efforts toward reducing those inequalities between corresponding subpopulations. This knowledge is crucial to inform the development and delivery of public health programs and policies that impact the general population, as well as certain vulnerable populations.

[2] Statistics Canada. CANSIM Table 102-0122.

[3] While HALE is still a relatively new summary measure of population health, methodological protocols for the routine measurement of HALE vis-à-vis income to present a picture of health inequalities is still evolving.

[4] The Agency collaborated on research projects with Public Health Ontario (regarding the impact of smoking, alcohol, diet, physical activity and stress on health and life expectancy in Ontario) and the Institut national de santé publique du Québec (regarding body mass index and HALE). Such findings and collaborations are crucial to informing the development and delivery of public health programs and policies across the country.

Program 1.1: Public Health Infrastructure

Program	Sub-Program
1.1 Public Health Infrastructure	1.1.1 Public Health Capacity Building
	1.1.2 Public Health Information and Networks
	1.1.3 Public Health Laboratory Systems

Description: This Program strengthens Canada's public health workforce capability, information exchange, federal/provincial/territorial networks, and scientific capacity. These infrastructure elements are necessary to support effective public health practice and decision-making in Canada. Working with federal, provincial and territorial stakeholders and within existing collaborative mechanisms, the Program supports planning for and building consensus on strategic and targeted investments in public health infrastructure, including training, tools, best practices, standards, and mechanisms to facilitate information exchange and coordinated action. Public health laboratories provide leadership in research, technical innovation and reference laboratory services; surveillance; outbreak response capacity; and national laboratory coordination. Through these capacity-building mechanisms and scientific expertise, the Government of Canada facilitates effective coordination and timely public health interventions which are essential to having an integrated and evidence-based national public health system. Key stakeholders include local, regional, provincial and national public health organizations, practitioners and policy makers, researchers and academics, professional associations and non-governmental organizations.

Financial Resources ($M)

Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending 2012–13	Total Authorities (available for use) 2012–13	Actual Spending (authorities used) 2012–13	Difference (Planned vs. Actual Spending) 2012–13
125.3	125.3	147.8	137.4	(12.1)

The variance between Planned and Actual Spending is primarily due to payments required under the International Health Grants Program and assessed contribution to the Pan American Health Organization that were transferred from HC to the Agency.

Human Resources (FTEs)

Planned 2012–13	Actual 2012–13	Difference 2012–13
768	751	17

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canada has public health system capacity to manage domestic public health emergencies of international concern	Level of Canada's compliance with the public health capacity requirements outlined in the International Health Regulations	Level 3: Advanced Baseline is 2.5 in June 2012	Level 2: Strong Technical Capacity
Canada is able to use highly specialized laboratory technologies to identify and characterize pathogens in support of public health surveillance and investigation of disease outbreaks	The number of pathogens for which molecular typing is offered by national laboratories	Baseline to be established	128

Performance Analysis and Lessons Learned

In June 2012, Canada met the WHO-recommended Capability Level 2 *International Health Regulations* (IHR) obligations by attaining basic surveillance and response capacities at designated airports, ports and certain ground-level border crossings. The Agency continued to enhance IHR core capacities by collaborating with F/P/T in developing a Pan-Canadian National Action Plan that could help Canada attain a Capability Level 3.

As the only Canadian public health institution with laboratories accredited to both the ISO 17025 and ISO 15189 standards, the Agency continued to perform to the highest quality standards in laboratory operations in support of its unique federal role to augment national public health capacity and increase Canada's preparedness to identify and respond to infectious disease threats. For instance, during 2012–13, the Agency provided its partners with positive controls to support Influenza A diagnostic testing; developed advanced analysis methods; and offered laboratory quality management training to international partners.

In addition, the Agency provided ongoing support for a tuberculosis outbreak in Nunavut as well as identified an emerging strain of Cache Valley virus, a pathogen that can be carried and transmitted by mosquitoes. Agency scientists also analyzed genetic traits in a group of sex workers who are resistant to HIV-1 infection. This resulted in the identification of a novel genetic marker which may impact the susceptibility to HIV-1 infection.

The Agency advanced cutting-edge development and use of bioinformatics and genomics for improved pathogen detection, discovery of antimicrobial resistance, and outbreak investigation. This ongoing work led to better understanding of disease transmission, improved timeliness of response, and enhancements in tracking outbreaks.

In its international role, the Agency provided input and technical expertise for a number of initiatives, including a WHO collaborative study to establish the first international standard for Hepatitis B e Antigen. Agency scientists also provided technical support and advice to the HIV Vaccine Trials Network and the Microbicide Trials Network.

Sub-Program 1.1.1: Public Health Capacity Building

Description: The Public Health Capacity Program contributes to the development and maintenance of a Canadian public health workforce which has the depth and capability to respond to public health issues and requirements at any time. Working with federal, provincial and territorial partners and stakeholders, the Program provides training and support to public health professionals to support this group to carry out core functions and respond effectively and cooperatively to public health events. The Program takes a leadership role in: developing strategies for public health human resources; identifying core competencies required for public health workforce; offering training for public health practitioners to be able to carry out core public health functions; strengthening national capacity to quickly respond to disease outbreaks and public health events; and providing funding to academia to strengthen and advance research and innovative methods in public health.

Financial Resources (SM) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
16.8	16.0	0.8

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
126	121	5

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Public health partners have the competencies and capabilities to execute their public health functions	Percent of PHAC field and emergency response staff who say that their competencies have improved	80% (by Mar. 2014)	81%
	Percent of public health practitioners who took PHAC training who are better equipped to perform public health functions	80% (by Mar. 2014)	79%
	Percent of public health host organizations who say that PHAC field staff contributed to their capacity to respond to public health events	80% (by Mar. 2014)	80%

Performance Analysis and Lessons Learned

Through the hiring and placement of six field epidemiologists and 20 public health officers across Canada, the Agency increased public health capacity, including in the North. Public health host organizations expressed a high level of satisfaction that these placements contributed to their capacity to respond to public health events. Furthermore, the Agency assisted in the management of public health events domestically and internationally by placing and mobilizing its staff to respond to emergency requests for assistance from public health partners. These requests helped the Agency to better understand and build the skills and competencies required when mobilizing public health professionals. This learning will assist the Agency in devising a more comprehensive competency-based strategy and training opportunities to further enhance public health capacity.

The Agency played a key role in enhancing public health partners' competencies and capabilities by offering 10 facilitated and two non-facilitated modules in public health in both official languages. Over 1,850 public health practitioners, including 70 from the North, enrolled in these

modules. Participant feedback highlighted the need for new training modules on *International Health Regulations*, *Introduction to Public Health*, *Core Competency Toolkit*, and *Program Evaluation*. The Agency also developed and delivered specialized public health training to public health officers, field epidemiologists, partners, and stakeholders across the country. Participant feedback from this training was also very positive.

Sub-Program 1.1.2: Public Health Information and Networks

Description: The Public Health Information and Networks Program facilitates federal, provincial, and territorial coordination and collaboration, and establishes core structures to facilitate access to accurate and reliable information, tools and models required by Canadian public health professionals to perform their public health duties effectively. Working with federal, provincial and territorial partners through the Public Health Network, the Program provides leadership by consulting and undertaking collaborative planning for public health strategies and addressing issues affecting the sharing of information for effective surveillance and action. The Program also invests in tools and processes to allow public health practice and core public health functions to be informed by evidence and applied knowledge; develops scenarios for population and public health research; and prepares models for economic analysis to support effective decision making.

Financial Resources (SM) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
25.2	34.1	(8.9)

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
85	80	5

Actual Spending was $8.9M higher than Planned Spending mainly due to payments required under the International Health Grants Program, including an assessed contribution to the Pan American Health Organization (PAHO) that moved from HC to the Agency.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Mechanisms are in place to enable public health partners to work collaboratively to address existing and emerging public health infrastructure issues	Number of provincial/territorial governments with whom information sharing agreements have been developed to facilitate access to data and information	4 (by Dec. 2014)	0
Public health organizations are engaged and participate in collaborative networks and processes	Percent of collaborative initiatives/projects delivered and/or on track based on work plans by fiscal year	70% (by Mar. 2014)	100%
Public health professionals and partners have access to reliable, actionable public health data and information	Percent of public health professionals and partners who responded that the Chief Public Health Officer's Report on the State of Public Health in Canada was useful	75% (by Mar. 2014)	87%

Performance Analysis and Lessons Learned

The Agency continued to work with P/T governments to develop a multi-lateral information sharing agreement to facilitate access to data and information, and is on track to meet its target of four jurisdictions signing by December 2014.

To increase access to public health data and information, the Agency developed the *PHAC Surveillance Strategic Plan 2013–2016* to renew the planning, alignment, and delivery of the Agency's public health surveillance activities. The plan includes concrete actions to address recommendations from the *Evaluation of the Surveillance Function at the Public Health Agency of Canada* which indicated that the Agency should take a more strategic approach to public health surveillance. The recommendations included: assuming a lead role in developing a shared F/P/T vision for public health surveillance function in Canada; establishing a formal mechanism and criteria to identify relative priorities for surveillance investments; and developing a more strategic approach to the approval and dissemination of surveillance products and information.

The Agency engaged public health organizations through the Public Health Network work plan which provided concrete, prioritized deliverables based on: appropriateness for F/P/T collaboration, rationale, alignment with ministerial and deputy ministerial direction, likelihood of success, and time and resources (required and already invested). Through such prioritization, collaborative initiatives/projects were delivered on time.

To provide access to information, the Agency produced the *CPHO's Report on the State of Public Health in Canada – 2012* which explored the influence of sex (i.e., biological characteristics) and gender (i.e., socio-cultural factors) on public health and the health status of Canadians. An online survey indicated that 87% of respondents reported had used (or were intending to use) the report: to support research papers/articles and presentations; as a reference document for general knowledge about sex and gender; for statistical data in presentations, research papers/articles; and to inform discussions or approaches to policy/programming.

Sub-Program 1.1.3: Public Health Laboratory Systems

Description: The Public Health Laboratory Systems Program is a national resource providing Canada with a wide range of highly specialized scientific and laboratory expertise and access to state of the art technologies. The Program informs public health professionals at all levels of government to enable evidence-based decision making in the management of and response to diseases and their risk factors. The Program conducts public health research; uses innovative approaches to advance laboratory science; performs reference laboratory services; contributes to public health surveillance; provides outbreak response capacity; and leads national public health laboratory coordination. The Program also addresses public health risk factors arising from human, animal and environmental interactions by conducting research, surveillance and population risk analysis. These combined efforts work to inform infectious and chronic disease-specific strategies and prevention initiatives. The knowledge generated and translated by the Program supports the development and implementation of national and international public health policies, guidelines, interventions, decisions and action that contribute to the lifelong health of the population.

Financial Resources (SM) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
83.4	87.3	(3.9)

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
557	550	7

The variance between Planned and Actual Spending is primarily due to new funding received for the operating and capital budget carry forward as well as the renewal of funding to enhance the Agency's ability to prevent, detect and respond to outbreaks of food-borne illness.

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Decisions and interventions to protect the health of Canadians are supported by research and reference/testing services	Percent of accredited reference laboratory tests that are conducted within the specific turnaround times (TAT)	90% (by Mar. 2014)	99%
	Percent of clients indicating overall satisfaction with laboratory reference services as "satisfied" or "very satisfied"	90% (by Dec. 2015)	95% (as of 2011)
	Citations to Agency laboratory research publications	1,500 (by Mar. 2014)	2,126

Performance Analysis and Lessons Learned

The Agency's PulseNet Canada team led the national laboratory response to the outbreak of *E. coli* O157:H7 infections associated with beef products during 2012–13. There were 18 cases identified from four provinces, and the investigation led to the recall of products nationwide. Agency scientists also developed new methods for the detection and isolation of *E.coli* O157 and non-O157 in agricultural waters.

The Agency developed a comprehensive online training course for laboratory partners, including P/Ts, on DNA fingerprinting for food-borne disease surveillance and outbreak response. The course will provide an efficient complement to one-on-one training for maintaining and further expanding F/P/T laboratories' on-site capabilities.

As the WHO-designated National Influenza Centre in Canada, the Agency collaborated with the WHO, the United States (U.S.) Centers for Disease Control and Prevention, and provincial partners to conduct national surveillance on seasonal influenza viruses. These surveillance activities included monitoring influenza activities, determining drug susceptibility, and detecting and describing changes to the circulating strains of influenza virus in Canada. Such surveillance information is vital for developing influenza prevention and treatment strategies for annual epidemics as well as pandemics.

Agency scientists continued to play a significant role in supporting research projects through the *Genomics Research and Development Initiative* (GRDI). As part of the GRDI, the Food and Water Safety Genomic Research and Development Initiative brought together federal expertise to address common concerns regarding two priority foodborne pathogens that represent serious risks to human health and negatively influenced agri-environmental regulations and trade.

Program 1.2: Health Promotion and Disease Prevention

Program	Sub-Program
1.2 Health Promotion and Disease Prevention	1.2.1 Infectious Disease Prevention and Control
	1.2.2 Conditions for Healthy Living
	1.2.3 Chronic (non-communicable) Disease and Injury Prevention

Description: This Program aims to promote better overall health of the population—with additional focus on those that are most vulnerable—by promoting healthy development among children, adults and seniors, reducing health inequalities, and preventing and controlling chronic and infectious diseases. Working in collaboration with provinces and territories, the Program develops and implements federal aspects of frameworks and strategies (e.g., *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*, national approaches to addressing immunization, HIV/AIDS) geared toward promoting health and preventing disease. The Program undertakes common primary public health functions of health promotion, surveillance, science and research on diseases and associated risk and protective factors to inform evidence-based frameworks, strategies, and interventions. It also undertakes health promotion and prevention initiatives, working with stakeholders to prevent and mitigate chronic disease and injury, and to help prevent and control infectious disease.

Financial Resources ($M)

Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending 2012–13	Total Authorities (available for use) 2012–13	Actual Spending (authorities used) 2012–13	Difference (Planned vs. Actual Spending) 2012–13
333.2	333.2	330.6	315.7	17.5

The variance of $17.5M between Planned and Actual Spending is mainly due to implementation of savings achieved through reduced spending on management and administration, travel, and professional services as well as administrative efficiencies in delivering grants and contributions programs.

Human Resources (FTEs)

Planned 2012–13	Actual 2012–13	Difference 2012–13
950	894	56

Actual FTEs were 56 fewer than Planned mainly due to implementation of savings achieved through reduced spending on management and administration, travel, and professional services as well as administrative efficiencies in delivering grants and contributions programs.

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Diseases in Canada are prevented and mitigated	Percent reduction over the next 3 years in the rate of indexed infectious diseases	2% (for entire 2011 to 2014 period)	Not available
	Percent change in rate of key chronic disease risk factors	GC targets for reduction of risk factors in consideration of F/P/T contexts and recommended global and regional voluntary targets by March 31, 2014, following finalization of the World Health Organization (WHO) and Pan American Health Organization's (PAHO) monitoring frameworks for Non-Communicable Diseases [5]	**Chronic Disease Risk Factors:** [6] **Physical Activity** 50.1% of population that reports being physically "active" or "moderately active" during their leisure-time, population aged 20+ years (2009–2011) **Healthy Weights** 31.5% of population that is overweight or obese (measured), children and youth aged 5–17 (2009–2011) **Healthy Eating** 44.1% of population that reports consuming fruit and vegetables at least 5 times/day, population aged 12+ years (2009–2010)

Performance Analysis and Lessons Learned

In collaboration with the National Advisory Committee on Immunization, the Agency launched an evergreen, online edition of the *Canadian Immunization Guide* that includes 21 new or updated chapters. The Guide has been an authoritative source for health professionals seeking information and recommendations on the use of vaccines since 1979.

Updated information on HIV transmission was published in 2012, and technical support was provided to researchers. Community organizations used the Agency's *Population-Specific HIV/AIDS Status Report: People from Countries where HIV is Endemic* to train stakeholders. This document informed discussions at the 2012 International AIDS Conference. The Agency was able to advance disease and population-specific enhanced behavioural surveillance work on a pilot study of Aboriginal Peoples in the Regina area and phase one study focusing on persons originating from HIV endemic countries.

In support of disease prevention and mitigation, the Agency participated in the global process

[5] Reporting on the existing F/P/T risk factor target for improved physical activity will continue until 2014–15. Starting in 2013, the Agency will report every two years on indicators for *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework to Promote Healthy Weights*. As well, the Agency will launch a *National Chronic Disease Indicator Framework* by March, 2014 as the foundation for chronic disease monitoring in Canada and to support Canada's reporting to the WHO and PAHO.

[6] Until GC targets are established, current statistical information on major risk factors is provided. These risk factors align with international targets established under the *Global Monitoring Framework* in May 2013.

that led to the *WHO Global Monitoring Framework and the 2013–2020 Global Action Plan for Noncommunicable Diseases*. The Action Plan guides efforts to scale up prevention of the four leading non-communicable diseases in order to achieve nine voluntary global targets by 2025.

Aligned with international objectives, the Agency continued collaborating with provinces and territories under *Curbing Childhood Obesity: A Federal Provincial Territorial Framework to Promote Healthy Weights*, including establishing indicators for childhood obesity trends and determinants that will support progress reporting on this significant public health issue. Completion of the *Indicator Framework for the Surveillance of Chronic Diseases and Associated Determinants in Canada* also contributed to systematic analysis and reporting of trends in risk factors and health outcomes.

The Agency worked with domestic public health stakeholders to develop targeted information including immunization guidance, behavioural and other risk factor research and surveillance, and program evaluations that identify effective interventions, in order to reduce the rates of AIDS/HIV, Tuberculosis (TB) and Hepatitis B and C. Where rates are not declining, and where there are indications of increased risk for disease, additional research and knowledge exchange activities were identified, so future public health efforts can be focussed in areas where the impact on disease rates and risk factors is greatest (e.g., among specific populations; using more integrated approaches; and technical innovation)

Sub-Program 1.2.1: Infectious Disease Prevention and Control

Description: The Infectious Disease Prevention and Control Program is the national focal point for efforts to help prevent, mitigate and control the spread and impact of infectious diseases in Canada. The Program provides leadership for integrating activities related to surveillance, laboratory science, epidemiology, research, promotion, modeling, intervention and prevention, including immunization. Applying an evidence-based approach, the Program informs targeted prevention and control initiatives for many infectious disease threats including acute respiratory and vaccine preventable infections (e.g., influenza, measles), sexually transmitted and bloodborne infections (e.g., Hepatitis B and C, HIV), hospital associated infections (e.g., C. difficile), and human diseases resulting from environmental exposures to food, water, animals and other vectors (e.g., Listeria, E.coli O157, West Nile virus). This Program reinforces efforts to protect the health and well-being of Canada's population, reduces the economic burden of infectious disease and provides expert advice to federal, provincial and territorial partners and stakeholders. The knowledge generated and translated by this Program influences and enables the development and implementation of public health policies, guidelines, interventions and action—including those required to meet Canada's *International Health Regulations* obligations—and helps to guide the population in their decisions regarding their personal health and that of their families.

Financial Resources ($M) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
52.5	54.5	(2.0)

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
324	319	5

Actual Spending was $2.0M greater than Planned Spending primarily due to the renewal of funding to enhance the Agency's ability to prevent, detect and respond to outbreaks of food-borne illness.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
New emerging and re-emerging infectious disease trends are identified and responded to in a timely manner	Percent of operational plans developed within six months to address new emerging and re-emerging infectious disease trends for non-outbreak situations	75% (by Mar. 2014)	100%
Maintain elimination status of measles, rubella, congenital rubella and polio	Percent of surveillance systems for measles, rubella, congenital rubella and polio that satisfy World Health Organization (WHO) standards	100% (by Mar. 2014)	100%
Actively engage Canadians on infectious disease issues	Percent uptake of information via social media outreach mechanisms	0.6% (by Mar. 2014)	N/A[7]

Performance Analysis and Lessons Learned

Two emerging pathogens were detected in ticks across in several regions in Canada using new testing methods as part of the Agency's tick surveillance program. Although the spectrum of disease caused by these bacteria is not fully understood, these discoveries highlight that ticks are transmitters of a variety of disease-causing pathogens in addition to the agent of Lyme disease, and demonstrate the utility of ongoing tick surveillance programs.

In collaboration with P/Ts, the Agency developed *Guidance for Tuberculosis Prevention and Control Programs in Canada* to provide decision-makers, program planners, public health practitioners, and health care providers with a comprehensive collection of best practices. While the *Evaluation of Community Associated Infections Prevention and Control Activities* recognized the work of the Agency in supporting efforts to reduce the rates of TB and other infections, further efforts will be required in the future.

The Agency provided leadership to support new approaches to vaccine innovation and development to meet evolving public health needs. This included convening a workshop on vaccine research, development and innovation with federal partners and external stakeholders to assess current capacity to leverage relevant scientific and technical advances.

In addition, the Agency initiated a pilot project to demonstrate and assess potential approaches to common guidance for vaccine use in Canada. Common-vaccine guidance would improve coordination and implementation of program schedules that help ensure timely, consistent and equitable coverage for intended populations nation-wide.

To provide up-to-date information to public health practitioners, the Agency released revised infection prevention and control guidelines and practices for acute care settings and long-term

[7] Baseline of 39,000 social media visits was established in 2012–13.

care facilities. In addition, a Web-enabled outbreak communications platform, *Outbreak Central*, was developed to facilitate the coordination and information sharing during food-borne and other outbreak investigations. The *Evaluation of Food-borne Enteric Illness Prevention, Detection and Response Activities* found a need for better understanding of the role of activities that aim to predict and prevent bacteria emergence before becoming a risk to humans. The Agency will seek to better align its science and research to inform federal food safety partners in the prevention of food-borne illness.

(Theme I: Addressing Climate Change and Air Quality)
The Agency supported the FSDS and the implementation of its *Departmental Sustainable Development Strategy*. The Agency contributed to the FSDS Theme I: Addressing Climate Change and Air Quality through the *2011–2016 Preventative Public Health Systems and Adaptation to Climate Change* programs.

Sub-Program 1.2.2: Conditions for Healthy Living

Description: The Conditions for Healthy Living Program improves health outcomes for Canada's population throughout their lives by promoting positive mental, social, and physical development, and by enabling the development of healthy communities. Population-wide health promotion efforts that respond to the needs of vulnerable and at-risk populations have been shown to improve health outcomes, especially in circumstances where poor social, physical or economic living conditions exist. The Program establishes a positive trajectory for health outcomes in early childhood, sustains healthy living conditions into youth and adolescence and builds individual and community capacity to support healthy transitions into later life. In collaboration with provinces, territories and stakeholders, and individuals directly impacted by a condition or disease the Program advances priorities and initiatives to promote healthy development. It also develops, tests, and implements evidence-based interventions and initiatives that can lead to positive changes in behaviour for those facing socially challenging circumstances (e.g., family violence, poor mental health, injuries, communicable infections, and social isolation). Finally, the Program exchanges evidence-based knowledge to inform public health policies, practices and programs, and helps to build community capacity.

Financial Resources ($M) 2012–13		
Planned Spending	Actual Spending	Difference
215.4	209.3	6.1

Human Resources (FTEs) 2012–13		
Planned	Actual	Difference
431	400	31

Variance between Planned and Actual Spending is mainly due to implementation of savings achieved through reduced spending on management and administration, travel, and professional services as well as administrative efficiencies in delivering grants and contributions programs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Programs, policies and practices to promote health and reduce health inequalities are informed by evidence	Level of usage of science and intervention research evidence in public health policies, practices, programs by key stakeholders	Average rating across key stakeholders is 7 or higher (by Mar. 2015)[8]	Data will be available in 2013–14[9]
Communities have the capacity to respond to health inequalities of targeted populations	Percent of Agency funded community organizations that leverage multi-sectoral collaborations in support of strengthening the social, mental and physical well-being and resiliency of at-risk populations	70% (by Mar. 2015)	89%[10]
	Percent of funded communities that have leveraged funds from other sources	50% (by Mar. 2015)	57%[11]

Performance Analysis and Lessons Learned

The Agency builds on lessons learned from projects funded through the *Innovation Strategy*. This intervention research program selects the most promising projects and further invests in their implementation, evaluation and knowledge sharing. For example, 20 out of 52 projects from a first phase received funding to continue work in a second phase focused on improving mental well-being and achieving healthier weights.

The *2011 CAPC National Study* indicated that CAPC projects are reaching the intended vulnerable population, increasing social support networks, and effectively linking participants to other services. A positive association was found between the CAPC and emotional wellbeing and positive child behaviour.

Results from the *Evaluation of the AHSUNC* show a significant improvement in participating children's school readiness skills (i.e., motor skills, language skills, and academic skills). Performance results demonstrated effectiveness in improving cultural literacy and in enhancing exposure to Aboriginal languages and cultures, as well as positive effects on health promoting behaviours such as children's access to daily physical activity and to health services.

The Agency developed the *Age-Friendly Communities in Canada: Community Implementation Guide* to help communities start up, implement, and evaluate their own age-friendly initiatives. The Agency also prepared a Mental Health Impact Assessment tool that takes into account the potential effects that a policy or program proposal may have on the mental health of its target

[8] The target is based on a rating scale of 1-10, with 1 being "low" and 10 being "high" level of usage of Agency-generated evidence by key decision makers when forming policy initiatives or programs.

[9] A number of science and intervention research products are being disseminated among key public health stakeholders to promote health and reduce health inequalities. Results on level of usage among stakeholders will be available in 2013–14, as planned.

[10] Funded through the Agency's children's programs, community projects targeting at-risk populations have proven to be successful at developing collaborations with local partners across various sectors. Going forward, the programs will build on current successes to enhance multi-sectoral collaborations in the area of early childhood development.

[11] Projects funded through programs (e.g., the AHSUNC, CAPC, and the CPNP) and through the *Innovation Strategy* have been successful in leveraging funding from other sources.

population, and tested messages to raise awareness about positive mental health and well-being amongst Canadians aged 16 and older.

To support health promotion and disease prevention in Canada's territories, a contribution agreement was signed with Nunavut under the *Northern Wellness Approach* to address sexual health-related priorities identified in Nunavut's *Public Health Strategy* and healthy living and disease prevention objectives. All territorial recipients began using a new performance measurement tool, which replaced previous evaluation tools that were found to be time consuming for project staff and duplicative for projects which accessed funds from multiple Agency programs. The new tool addresses these identified issues and the burden on small communities by enabling the collection of information for all programs in one document.

Sub-Program 1.2.3: Chronic (non-communicable) Disease and Injury Prevention

Description: The Chronic (non-communicable) Disease and Injury Prevention Program mobilizes and supports government and non-governmental organizations at national, P/T and local levels, and collaborates with international/national multi-sectoral stakeholders in designing, evaluating and identifying best practices, with the goal that policies and Programs support healthy living, decrease chronic disease rates and reduce the impact of these diseases on Canada's population. This is necessary because two in five persons in Canada are living with a chronic disease (e.g., diabetes, cancer, cardiovascular disease, lung diseases) and four in five are experiencing at least one risk factor for chronic disease such as physical inactivity, overweight, or obesity. This Program works to track injuries, chronic diseases, their risk factors and related inequalities, and analyses the risks to public health, and determines priorities for action. It also identifies what works in chronic disease prevention and mitigation, according to scientific criteria, and disseminates these approaches widely to increase the use of effective interventions. Finally, it facilitates collaboration among stakeholders to increase the efficiency and effectiveness of chronic disease prevention and mitigation. Program activities are geared toward developing a coherent national approach to chronic disease prevention and mitigation with stakeholders and partners, which will reduce the impact of chronic diseases for persons living in Canada and the health care system.

Financial Resources ($M) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
65.3	51.9	13.4

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
195	175	20

Variance between Planned and Actual Spending is mainly due to implementation of savings achieved through reduced spending on management and administration, travel, and professional services as well as administrative efficiencies in delivering grants and contributions programs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Chronic disease prevention priorities for Canada are identified and advanced	Percent of key stakeholders who agree that chronic disease and injury priorities have been advanced through collaboration with PHAC	70% (Mar. 2015)	76%[12]
Chronic disease prevention practice, programs and policies for Canadians are informed by evidence	Level of usage of evidence in chronic disease and injury policies and programs by key stakeholders	Average rating across key stakeholders is 7 or higher (Mar. 2015)[13]	7.2[14]
	Percent of key stakeholders using best and promising practices/interventions to inform chronic disease and injury prevention practice	70% (Mar. 2015)	Data will be available in 2014–15[15]

Performance Analysis and Lessons Learned

To better leverage its resources for chronic disease prevention, the Agency established a new funding model to promote innovative, multi-sectoral collaborations and maximize their impact on health outcomes. A collaboration with AIR MILES for Social Change and the YMCA was established to encourage children and their families to get active and stay active over the long term. As well, the Agency supported the expansion of the Get BUSY program which focuses on healthy eating and physical activity among children in the after-school time period with the Boys and Girls Clubs of Canada and Sun Life Financial.

The Agency continued to strengthen the evidence to support chronic disease prevention. Scientific support was provided to the independent Canadian Task Force on Preventive Health Care for the development of clinical practice guidelines on diabetes, hypertension and cervical cancer screening. The Agency also collaborated on the development of the "Prevention in Hand" Web site, which provides health care practitioners with tools to support healthy behaviours among their patients. Furthermore, the Agency completed projects to address information gaps as part of the *National Population Health Study of Neurological Conditions* and began work on the synthesis report of the results from these projects.

The Agency began working with P/Ts to facilitate data sharing and data quality assessments for the Canadian Congenital Anomalies Surveillance System in addition to working with P/Ts on key aspects of the Autism Spectrum Disorders Surveillance System.

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[12] Of the 41 neurological stakeholders surveyed, 31 (76%) rated the success of the collaborative approach as excellent or good. The proxy data on neurological stakeholders generated from the pre-test of the *Partnership Engagement Outcome Tool* is being used to report against this indicator and is not representative of all partnerships undertaken within the Sub-Program. A comprehensive data set that speaks to the performance of this Sub-Program will be available by March, 2015.

[13] The target is based on a rating scale of 1-10, with 1 being "low" and 10 being "high" level of usage of Agency-generated evidence by key decision makers when forming policy initiatives or programs.

[14] Of the 329 stakeholders surveyed, 236 (72%) have used the Agency's products or intend to use them in the future. Proxy data generated from the *Stakeholder Satisfaction with Knowledge Products Pilot Survey* is being used to report against this indicator. Data from the survey are seen as an early indicator of other expected results such as knowledge uptake. Results are reported from five data sets only and are not representative of all knowledge products, nor should they be considered as a baseline. The planned reporting date for this indicator remains March 2015.

[15] No proxy data are available for this indicator. The planned reporting date for this indicator is March 2015. Work to develop an outcome tool to measure use of best and promising practices/interventions will begin in 2013–14.

The Agency expanded the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) to two new hospitals, for a total of 17 and started converting CHIRPP to an electronic format to provide timely information on children's injuries, risk factors, and an early warning system to monitor consumer product hazards. Progress on injury prevention was made through the Lifesaving Society and Canadian Red Cross campaign in 268 communities to prevent drowning in open waters as well as the training of 66 new instructors for the CAN-BIKE safe cycling course.

Program 1.3: Health Security

Program	Sub-Program
1.3 Health Security	1.3.1 Emergency Preparedness and Response
	1.3.2 Border Health Security
	1.3.3 Biosecurity

Description: This Program takes an all hazards approach to the health security of Canada's population, which provides the GC with the ability to prepare for and respond to public health issues and events. This Program seeks to bolster the resiliency of the population and communities, thereby enhancing the ability to cope and respond. To accomplish this, its main methods of intervention include actions taken through partnerships with key jurisdictions and international partners. These actions are carried out through the implementation and maintenance of *International Health Regulations* and through the administration and enforcement of legislation, including the *Emergency Management Act*, the *Quarantine Act*, the *Human Pathogens and Toxins Act* and the *Human Pathogens Importation Regulations*.

Financial Resources ($M)

Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending 2012–13	Total Authorities (available for use) 2012–13	Actual Spending (authorities used) 2012–13	Difference (Planned vs. Actual Spending) 2012–13
62.6	62.6	76.6	60.0	2.6

The variance of $2.6M between Planned and Actual Spending is mostly due to lower spending for the pandemic vaccine fill-line and lower orders received from provinces and territories for the NAS, offset by additional purchases for the National Emergency Stockpile System (NESS).

Human Resources (FTEs)

Planned 2012–13	Actual 2012–13	Difference 2012–13
236	220	16

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Canada has the partnerships and regulatory frameworks to prevent, prepare for and respond to threats to public health	Percent of partnerships with key jurisdictions and international partners in place to prepare for and respond to public health issues and events	80%	90%
	Percent of GC's health emergency and regulatory programs implemented in accordance with the *Emergency Management Act*, the *Quarantine Act*, the *Human Pathogens and Toxins Act* and the *Human Pathogens Importation Regulations*	80% (Dec. 2015)	80%

Performance Analysis and Lessons Learned

The Agency's emergency operations infrastructure supported and facilitated emergency/event operations through the 24/7 Watch Office Program and the Global Public Health Intelligence Network. As the IHR's National Focal Point Office, the Agency links Canada with the WHO/Pan American Health Organization and public health authorities around the world.

The Canada-U.S. cooperation plan under the Health Security Task Force of the *Beyond the Border Initiative* is in the final stages of negotiation with U.S. partners. Through the *Beyond the Border Initiative*, Canada is able to reduce the impacts of shared health security risks through expanded bilateral collaboration with the U.S. to advance North American biosecurity and pathogen control.

Collaborative activities with F/P/T and international partners proved to be an important approach to advancing Canada's health and security agenda, and strengthened the Canada's capacities to detect, assess, notify and respond to public health risks and emergencies of national and international concern as specified in the IHR.

Sub-Program 1.3.1: Emergency Preparedness and Response

Description: The Emergency Preparedness and Response Program is the central coordinating point among federal, provincial, territorial and non-governmental public health partners. The Program is also responsible for strengthening the nation's capacity to help prevent, mitigate, prepare and respond to public health emergencies. In order to meet these goals, the Program's interventions include emergency preparedness, emergency planning, training and exercises, ongoing situational awareness and risk assessment, maintenance of a Health Portfolio Emergency Operations Centre, coordination of inter-jurisdictional mutual aid, deployment of surge capacity to provinces and territories, and deployment of Microbiological Emergency Response Teams and associated mobile laboratories. The Program seeks to protect all persons living in Canada and provides surge capacity to provinces and territories and fulfills Canada's international obligations for outbreak events, such as infectious disease, pandemic influenza and bioterrorism. In addition, it coordinates response to national or manmade disasters and preparedness for mass gathering and high profile events. The Program supports the continued implementation of the *Emergency Management Act* and *International Health Regulations*, and it

also makes a significant contribution to the *Beyond the Border* Initiatives and to the *North American Plan for Animal and Pandemic Influenza*.

Financial Resources ($M) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
50.5	48.6	1.9

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
144	139	5

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Canada has the capacity to prevent, mitigate, prepare and respond to public health emergencies including infectious diseases	Percent of all-hazards and disease specific plans and procedures developed, maintained and kept current at all times	80% (Apr. 2015)	95%
	Percent of inter-jurisdictional mutual aid assistance requests coordinated for domestic and international response and resource sharing within negotiated timelines	90%	100%
	Percent of required Health Portfolio capabilities ready to respond to events/emergencies on 24/7 basis	100%	100%

Performance Analysis and Lessons Learned

The Agency worked through the Health Portfolio's Emergency Preparedness Committee to develop and implement a *Health Portfolio Public Health Emergency Risk Assessment* which forms an appendix to the *Health Portfolio Strategic Emergency Management Plan* (HP SEMP). This Plan articulates roles and responsibilities related to situational awareness, risk assessment, planning, and training for the advancement of emergency management in Canada. In addition, the *Health Portfolio Emergency Response Plan* was revised to reflect changes at both the governance and operational levels.

Focusing on potential bioterrorism threats/risks, the Agency developed an all-hazards threat and risk assessment tool with the Health Portfolio that supports the *Global Health Security Initiative Threat and Risk Assessment*. The assessment tool was shared with key stakeholders and will be discussed as part of *Beyond the Border* deliverables with the U.S.

The *Operational Framework for Mutual Aid Response* for use during emergencies was tested and validated through a series of table top exercises. The framework supports the 2009 F/P/T Memorandum of Understanding on the provision of mutual aid in relation to health resources during an emergency affecting the health of the public.

In response to the *Evaluation of the National Emergency Stockpile System* (NESS) and other reviews, the Agency continued to modernize the NESS through the implementation of an inventory management system, the introduction of risk-informed and evidence-based asset acquisition and disposal processes, and the development of a comprehensive policy management frame.

In collaboration with P/Ts, the Agency prepared the *Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector* which incorporated a risk management approach and pandemic planning scenarios. This document helps to address the recommendations from the *Senate Committee Report on Canada's Response to the 2009 H1N1 Influenza Pandemic* and the *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic* to make the CPIP more flexible and responsive.

Sub-Program 1.3.2: Border Health Security

Description: The Border Health Security Program builds and maintains the health security of the Canadian population by implementing public health measures across borders. The Program includes communicable disease control and environmental health services activities to help maintain public health and provide information to international travellers. This is done by helping to prevent the introduction of communicable diseases into or from Canada. This Program administers and enforces the *Quarantine Act* as it relates to international travelers and conveyances arriving in or departing from Canada. The issuance of Ship Sanitation Certificates to international vessels, the implementation of passenger terminal and passenger transportation inspection Programs (conveyances), and responding to passenger conveyance gastrointestinal disease outbreaks also help to prevent the introduction and spread of communicable diseases. The Border Health Security Program promotes coordinated border health measures by creating linkages between key border departments and agencies, including the Canadian Border Services Agency, Royal Canadian Mounted Police, and the Canadian Food Inspection Agency.

Financial Resources ($M) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
2.5	3.0	(0.5)

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
22	21	1

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Risks associated with import and export of communicable diseases into and out of Canada are mitigated and/or controlled	Percent of inspected passenger conveyances (ships, planes, trains) that meet federal guidelines	75%	Refer to footnote[16]
	Percent of Canadian points of entry that have capacities implemented as stated in the IHR.	100% (Dec. 2015)	100%

Performance Analysis and Lessons Learned

The Agency maintained 24/7 capacity to respond to potential quarantine events at border sites, supporting Canada's commitment to IHRs. In addition, the Agency worked with local partners to support education and training on roles and responsibilities under the *Quarantine Act* to improve

[16] This new indicator will be reported in the Agency's 2013–14 DPR. The Travelling Public program for 2012–13 is reported under Sub-Program 2.3.5: Public Health Inspections on Passenger Conveyances in the HC 2012–13 DPR.

clarity about the roles of the Agency, the Canada Border Services Agency, emergency responders, as well as local, provincial and territorial health authorities.

To reduce the risk of communicable disease importation and exportation by humans, conveyances, and cargo, the Agency prepared for the integration of HC's Travelling Public program with the Agency's Quarantine program as of April 1, 2013. This integration will enhance Canada's capacity at the border to detect and respond to health risks through streamlined services for stakeholders.

Sub-Program 1.3.3: Biosecurity

Description: The Biosecurity Program is responsible for administration and enforcement activities related to the use and manipulation of human, terrestrial animal pathogens, and toxins. This Program has specific responsibility under the *Human Pathogens and Toxins Act* and the *Human Pathogens Importation Regulations*, and select sections of the *Health of Animals Act* to promote and enforce safe and secure biosafety practices and laboratory environments. The Program's main methods of intervention include the issuance of import permits, laboratory inspections, lab certification and verification, education through the provision of knowledge products and training, and compliance and enforcement activities. Researchers, industries, hospitals and laboratories that handle pathogens and toxins are provided with regulatory oversight—including laboratory certification, inspection, guidance and the issue of importation permits. This Program further contributes to the health security of the population by mitigating risks posed by pathogen misuse such as a deliberate release or the intentional production of bioterrorism agents.

Financial Resources ($M) 2012–13		
Planned Spending	**Actual Spending**	**Difference**
9.6	8.4	1.2

Human Resources (FTEs) 2012–13		
Planned	**Actual**	**Difference**
70	60	10

Performance Results

Expected Result	Performance Indicators	Targets	Actual Results
Safe and secure biosafety practices and laboratory environments	Percent of federally registered laboratories working with moderate risk pathogens and toxins compliant with requirements	Target to be established	90%
	Percent of federally registered laboratories working with high risk pathogens and toxins compliant with requirements	80% (Apr. 2015)	86%
	Percent decrease of laboratory acquired infections and undesired events	Establish baseline	TBD

Performance Analysis and Lessons Learned

The programs of the Canadian Food Inspection Agency (CFIA) and the Agency that issue pathogen import permits, certify laboratories handling animal and human pathogens, and provide guidance on biosafety and bio-containment, were consolidated to eliminate regulatory

duplication and administrative burden on stakeholders while continuing to protect the health and safety of Canadians. In collaboration with the CFIA, the Agency completed the *Canadian Biosafety Standards and Guidelines* (CBSG). This document is the first joint human and animal bio-containment standard in the world. The CBSG represents a significant achievement for the Agency as it forms the biosafety foundation for the entire *Human Pathogens and Toxins Act* (HPTA) initiative and much of the program and regulatory framework.

In keeping with the Agency's improved service delivery to its regulated parties, *Online Smart Forms* were launched for import permit applications to reduce the administrative burden, increase the accuracy of submissions, and support improved turnaround times.

The Agency has continued to make significant progress on the design and development of the program and regulatory framework for the HPTA. In March 2013, cross-Canada consultations and engagement were launched to challenge and test specific ideas and options prior to drafting policy instruments and implementing key program elements. The Agency has also made progress in establishing a process for the rigorous analysis of this eventual program and regulatory framework. Notably, a Privacy Impact Assessment of the existing program will be used to address concerns and issues throughout the regulatory design process. Finally, international partners have been engaged with a view to establishing a strong scientific foundation for any proposed containment requirements.

Face-to-face consultations with stakeholders in support of the *HPTA Program and Regulatory Framework* development generated collateral benefits by enabling the Agency to identify what worked well and what may need improvement to identify evolving trends amongst stakeholder groups and specific needs they may have to address. This information will inform the *HPTA Program and Regulatory Framework* as well as program delivery.

Program 2.1: Internal Services

Program	Sub-Program	Sub-Sub-Program
2.1 Internal Services	2.1.1 Governance and Management Support	2.1.1.1 Management and Oversight
		2.1.1.2 Communications
		2.1.1.3 Legal
	2.1.2 Resource Management Services	2.1.2.1 Human Resource Management
		2.1.2.2 Financial Management
		2.1.2.3 Information Management
		2.1.2.4 Information Technology
		2.1.2.5 Travel and Other Administrative Services
	2.1.3 Asset Management Services	2.1.3.1 Real Property
		2.1.3.2 Material
		2.1.3.3 Acquisitions

Description: This Program supports the Agency's strategic outcome and all of its Programs. Internal Services are groups of related activities and resources that are administered to support the needs of Programs and other corporate obligations of an organization. These groups are Management and Oversight Services, Communications Services, Legal Services, Human Resources Management Services, Financial Management Services, Information Management Services, Information Technology Services, Real Property Services, Materiel Services, Acquisition Services, and Travel and Other Administrative Services. Internal Services include only those activities and resources that apply across the Agency and not those provided specifically to a Program.

Financial Resources ($M)

Total Budgetary Expenditures (Main Estimates) 2012–13	Planned Spending 2012–13	Total Authorities (available for use) 2012–13	Actual Spending (authorities used) 2012–13	Difference (Planned vs. Actual Spending) 2012–13
95.4	95.4	109.4	106.5	(11.1)

The variance between Planned and Actual Spending is due to the spending of revenues authorities received for the SSP.

Human Resources (FTEs)

Planned 2012–13	Actual 2012–13	Difference 2012–13
714	353	361

The variance between Planned and Actual FTE utilization is mainly due to the transfer of various programs between HC and the Agency as part of the SSP.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The communications, service operations and programs of the Agency comply with applicable laws, regulations, policies and plans and meet the diverse needs of the public	Compliance with the GC *Communications Policy*	100%	100%
	Compliance with the statutory time requirements of the *Access to Information Act* and *Privacy Act*	Achieve an Office of the Information Commissioners Rating "A" Rating (95%)	*Access to Information Act*– 79% *Privacy Act*– 82%
	Compliance with the GC *Official Languages Act*, Part IV, Communications with and services to the public	100%	100%
Strategic allocation and prudent use of resources among programs, processes and services	% Year-end Agency variance of planned versus actual expenditures	5% variance or less	0.5%
	Compliance with the GC *Employment Equity Act*	Achieve a work force representative of work force availability estimates based on the 2006 Census by March 31, 2013: Aboriginal People – 3.1% Persons with Disabilities – 4.3% Visible Minorities – exceed 13.1% Women – 61.8%	Aboriginal People – 3.6% Persons with Disabilities – 6.1% Visible Minorities – 18.3% Women – 68.9%
Assets are acquired and managed in a sustainable and financially responsible manner throughout the lifecycle	% of compliance with legislation, regulations, policies, standards and best practices	100%	100%

Performance Analysis and Lessons Learned

The Agency consistently worked to provide Canadians with information to promote healthy living and to protect from diseases such as diabetes, *E. coli* infection, and influenza, among others. Working with P/T and international partners and stakeholders to promote public health activities and share information pertaining to emerging events has also been a key focus. Protocols for Health Emergency Risk Communications were revised in concert with the revision of the Health Portfolio Emergency Response Plan.

In 2012–13, due to the large number of total requests (17% increase from the previous year), and the complexity of the files received, the Agency fell short of the 95% access to information and privacy targets. This increased workload is part of a trend that has seen a 65% increase in requests over the past five years. The Agency has undertaken a number of activities to increase its compliance with legislative timelines outlined in the acts, including the establishment of a

shared service with HC and procurement of a new case management and imaging system. Communication and information sharing are key to the success of the transition to a shared services model as well as supporting a learning and innovative environment to achieve results in line with organizational goals.

The Agency took a proactive approach on diversity and employment equity by preparing a progress report on the *2011–12 Diversity and Employment Plan* and also began consultations for the new *2013–2016 Multi-Year Diversity and Employment Plan* for the Agency and HC. Agency employees were also encouraged to join various employee networks to provide a voice and support to Visible Minorities, Aboriginal Peoples, and Persons with Disabilities.

(Theme IV: Shrinking the Environmental Footprint – Beginning with Government)
The Agency is a participant in the FSDS and contributes to the Greening Government Operations targets through the Internal Services Program. The Agency contributes to the following target areas of Theme IV of the FSDS:

- Green Buildings;
- Surplus Electronic and Electrical Equipment;
- Printing Unit Reduction;
- Paper Consumption;
- Green Meetings; and
- Green Procurement.

For additional details on the Agency's Greening Government Operations activities, please refer to Section III: Supplementary Information Tables found on the Agency's Web site.

Section III: Supplementary Information

Financial Statements Highlights

Condensed Statement of Operations and Departmental Net Financial Position

Public Health Agency of Canada Condensed Statement of Operations and Departmental Net Financial Position (Unaudited) For the Year Ended March 31, 2013 ($M)					
	2012–13 Planned Results (Restated)*	2012–13 Actual	2011–12 Actual (Restated)*	$ Change (2012–13 Planned vs. Actual)	$ Change (2012–13 Actual vs. 2011–12 Actual)
Total expenses	650.5	584.5	658.3	66.0	(73.8)
Total revenues	0.1	0.0	0.0	0.1	0.0
Transferred operations	0.0	0.0	3.2	0.0	(3.2)
Net cost of operations before government funding and transfers	650.5	584.5	661.5	66.0	(77.0)
Departmental net financial position	74.6	101.0	42.9	(26.4)	58.1

Note: All figures are rounded.
*Please refer to the Agency's *2012–13 Financial Statements* for further details.

Total revenues for 2012–13 Planned Results have been restated to the correct amount of $0.1M. The Departmental net financial position for 2011–12 Actual has been restated due to a reinterpretation of the application of Treasury Board Accounting Standards as they relate to the calculation of amounts due from the Consolidated Revenue Fund.

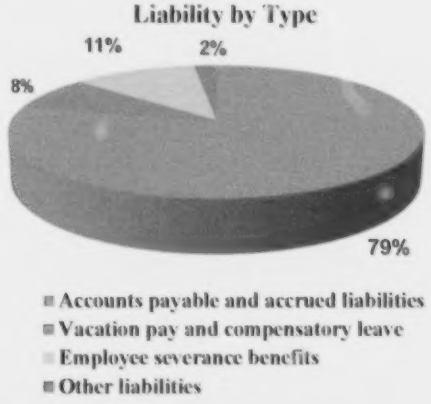
The $66.0M change between Planned Results vs. Actual Expenses is mostly due to savings achieved through reduced spending on management and administration, travel, and professional services, as well as administrative efficiencies in delivering grants and contributions programs. The $73.8M change between 2012-13 vs. 2011-12 Actual Expenses is mostly due to a decrease in salaries and employee benefits resulting from workforce adjustment costs expensed in the prior year, and a decrease in costs associated with the accumulation and liquidation of severance pay due to changes in some collective agreements, as well as savings achieved through the implementation of business transformation initiatives and administrative efficiencies.

The Agency receives most of its funding through annual parliamentary appropriations. Almost all revenue generated from Programs is non-respendable and earned on behalf of Government. All cash received by the Agency is deposited to the Consolidated Revenue Fund, and all cash disbursements made by the Agency are paid from it.

Condensed Statement of Financial Position

Public Health Agency of Canada Condensed Statement of Financial Position (Unaudited) As at March 31, 2013 ($M)			
	2012–13	2011–12 (Restated)*	$ Change
Total net liabilities	120.7	142.2	(21.5)
Total net financial assets	93.8	64.5	29.3
Departmental net debt	26.9	77.7	(50.8)
Total non-financial assets	127.9	120.6	7.3
Departmental net financial position	101.0	42.9	58.1

Note: All figures are rounded.
*Please refer to the Agency's *2012–13 Financial Statements* for further details.



Total assets were $221.7M, an increase of 20% ($36.7M) in comparison to the previous year's total of $185.0M. The increase was primarily due to the increased amount required from the consolidated revenue fund for liabilities. Due from consolidated revenue fund represented $90.3M (41%); accounts receivable and advances represented $3.5M (1%); and tangible capital assets represented $127.9M (58%) of total assets.

Total liabilities were $120.7M, a decrease of 15% ($21.4M) in comparison to the previous year's total of $142.2M. The decrease was primarily due to the cessation and payments of severance benefits arising from changes to collective bargaining agreements. Accounts payable and accrued liabilities represented $94.9M (79%); vacation pay and compensatory leave represented $9.5M (8%); employee severance benefits represented $13.8M (11%); and other liabilities represented $2.5M (2%) of total liabilities.

Financial Statements

The Agency's *2012–13 Financial Statements* are available online.

Supplementary Information Tables

All electronic supplementary information tables listed in the *2012–13 Departmental Performance Report* can be found on the Agency's Web site:

- Details on Transfer Payment Programs
- Greening Government Operations
- Horizontal Initiatives
- Internal Audits and Evaluations
- Response to Parliamentary Committees and External Audits
- Sources of Respendable and Non-Respendable Revenue
- Status Report on Projects Operating with Specific Treasury Board Approval

Tax Expenditures and Evaluations Report

The tax system can be used to achieve public policy objectives through the application of special measures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of Finance publishes cost estimates and projections for these measures annually in the *Tax Expenditures and Evaluations* publication. The tax measures presented in the *Tax Expenditures and Evaluations* publication are the sole responsibility of the Minister of Finance.

Section IV: Other Items of Interest

Organizational Contact Information

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Web Sites

Aboriginal Head Start in Urban and Northern Communities (AHSUNC)	http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/ahsunc-papacun/index-eng.php
Access to Information Act	http://laws-lois.justice.gc.ca/eng/acts/A-1/index.html
Age-Friendly Communities in Canada: Community Implementation Guide	http://www.phac-aspc.gc.ca/seniors-aines/publications/public/afc-caa/guide/index-eng.php
AIR MILES for Social Change and the YMCA	http://www.phac-aspc.gc.ca/media/nr-rp/2013/2013_0220-eng.php
Autism Spectrum Disorders Surveillance System	http://www.hc-sc.gc.ca/hc-ps/dc-ma/autismsurv-eng.php
Boys and Girls Clubs of Canada - Get BUSY Program	http://www.bgccan.com/en/ClubsPrograms/Programs-National/Pages/Get-Busy.aspx
Cabinet Directive on the Environmental Assessment of Policy, Plan and Program Proposals	http://www.ceaa.gc.ca/default.asp?lang=En&n=B3186435-1
Canada Prenatal Nutrition Program	http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/cpnp-pcnp/index-eng.php
Canadian Biosafety Standards and Guidelines (CBSG)	http://canadianbiosafetystandards.collaboration.gc.ca/
Canadian Immunization Guide	http://www.phac-aspc.gc.ca/publicat/cig-gci/
Canadian Red Cross - Swimming and Water Safety	http://www.redcross.ca/what-we-do/swimming-and-water-safety
Canadian Task Force on Preventive Health Care	http://canadiantaskforce.ca/
CAN-BIKE	http://www.canbike.net/cca_pages/index.htm
CPHO's Report on the State of Public Health in Canada – 2012	http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2012/index-eng.php
Communications Policy	http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=12316
Community Action Program for Children (CAPC)	http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/capc-pace/index-eng.php
Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights	http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/framework-cadre/index-eng.php
Departmental Performance Report (DPR)	http://www.phac-aspc.gc.ca/about_apropos/dpr-rmr/index-eng.php

E. coli O157:H7 infections	http://www.phac-aspc.gc.ca/fs-sa/fs-fi/ecoli-eng.php
Employment Equity Act	http://laws-lois.justice.gc.ca/eng/acts/E-5.401/index.html
Environment Canada – Federal Sustainable Development Strategy (FSDS)	http://www.ec.gc.ca/dd-sd/default.asp?lang=En&n=C2844D2D-1
Evaluation of Community Associated Infections Prevention and Control Activities	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2012-2013/ipca-pcia/index-eng.php
Evaluation of Food-borne Enteric Illness Prevention, Detection and Response Activities	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2011-2012/feipdra-pdimcoa/index-eng.php
Evaluation of the AHSUNC	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2011-2012/ahsunc-papacun/index-eng.php
Evaluation of the National Emergency Stockpile System (NESS)	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2010-2011/ness-srnu/index-eng.php
Evaluation of the Surveillance Function at the Public Health Agency of Canada	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2012-2013/sf-fs/index-eng.php
Genomics Research and Development Initiative (GRDI)	http://grdi-irdg.collaboration.gc.ca/eng/about/index.html
Guidance for Tuberculosis Prevention and Control in Canada	http://www.phn-rsp.ca/pubs/gtbpcp-oppctbc/pdf/Guidance-for-Tuberculosis-Prevention-eng.pdf
Health-Adjusted Life Expectancy in Canada: 2012 Report by the Public Health Agency of Canada	http://www.phac-aspc.gc.ca/cd-mc/halc-evas-eng.php
Health Portfolio	http://www.hc-sc.gc.ca/ahc-asc/minist/portfolio/index-eng.php
Human Pathogens and Toxins Act (HPTA)	http://www.phac-aspc.gc.ca/lab-bio/regul/hpta-lapht-eng.php
Impact of smoking, alcohol, diet, physical activity and stress on health and life expectancy in Ontario	http://www.ices.on.ca/file/HealthImpact_ICES_Summary_web%5b1%5d.pdf
Innovation Strategy	http://www.phac-aspc.gc.ca/ph-sp/fund-fonds/index-eng.php
Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic	http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2010-2011/h1n1/index-eng.php
Lifesaving Society	http://www.lifesavingsociety.com/who's-drowning.aspx
National Population Health Study of Neurological Conditions	http://www.mybrainmatters.ca/en/national-population-health-study-neurological-conditions
National Collaborating Centre on Environmental Health – continuing education directory	http://ncceh.ca/en/professional_development/continuing_education
Northern Wellness Approach	http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-54bk-eng.php
Official Languages Act	http://laws-lois.justice.gc.ca/eng/acts/O-3.01/index.html
Online Smart Forms	http://www.phac-aspc.gc.ca/lab-bio/permits/assets/pdf/permit-permis-eng.pdf
Pan-Canadian Age-Friendly Communities Initiative	http://www.phac-aspc.gc.ca/seniors-aines/afc-caa-eng.php#sec3
Population-Specific HIV/AIDS Status Report: People from Countries where HIV is Endemic	http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/africacaribbe/index-eng.php
Prevention in Hand	http://204.187.39.30/cdp/
Privacy Act	http://laws-lois.justice.gc.ca/eng/acts/P-21/

Public Accounts of Canada 2013 (Volume II)	http://www.tpsgc-pwgsc.gc.ca/recgen/cpc-pac/index-eng.html
Public Health Agency of Canada (Agency)	http://www.phac-aspc.gc.ca/index-eng.php
Public Health Agency of Canada (Financial Statements)	http://www.phac-aspc.gc.ca/about_apropos/dpr-rmr/fs-ef/2012-2013/index-eng.php
PulseNet Canada	http://www.nml-lnm.gc.ca/Pulsenet/index-eng.htm
Quarantine Act	http://laws-lois.justice.gc.ca/eng/acts/Q-1.1/index.html
Screening for Type 2 Diabetes	http://canadiantaskforce.ca/guidelines/2012-diabetes/
Screening for Hypertension	http://canadiantaskforce.ca/guidelines/screening-for-hypertension/
Screening for Cervical Cancer	http://canadiantaskforce.ca/guidelines/screening-for-cervical-cancer/
Senate Committee Report on Canada's Response to the 2009 H1N1 Influenza Pandemic	http://www.parl.gc.ca/content/sen/committee/403/soci/subsitedcc10/report_home-e.htm
Skills Online	http://www.phac-aspc.gc.ca/php-psp/ccph-ccsp/about_so-apropos_cd-eng.php
Sustainable Development	http://www.phac-aspc.gc.ca/about_apropos/sd-dd/index-eng.php
Tax Expenditures and Evaluations	http://www.fin.gc.ca/purl/taxexp-eng.asp
WHO Global Monitoring Framework and the *2013–2020 Global Action Plan for Noncommunicable Diseases*	http://www.who.int/nmh/en/
Whole-of-Government Framework	http://www.tbs-sct.gc.ca/ppg-cpr/frame-cadre-eng.aspx